STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:
Based on observation, interview and record review, the facility failed to assess, monitor, treat per physician's orders and provide adequate pressure relief to prevent the development of pressure ulcers for one of two residents (R2 and R1) reviewed with pressure ulcers. This resulted in R2 developing one Stage 3 and 4 Unstageable pressure ulcers to her left leg and foot/toes.

Findings include:

1. R2's Hospital Discharge Plan, dated 8/2/2015, documents R2 was discharged from the Hospital Emergency Department with a left leg fracture. The Hospital "Patient Instructions" and "Activity Restrictions or Additional Instructions", dated 8/2/2015 documents "The nursing staff may remove the boot for skin care, neuro, and skin checks per their protocols. "

R2's Physician's Order Sheet (POS) had orders from Z1, Orthopedic Physician, dated 8/3/15 to continue in boot with instructions provided.

On the Treatment Administration Record, (TAR) Z1, Orthopedic Physician documented, " 8/3/15-8/12/15 Patient's Diagnosis, (DX), distal fibial fracture, (FX). Patient is to be strictly non weight bearing, including no use of foot to scoot around in wheelchair. Continue boot with instructions provided." On 8/12/15, Z1 documented on the TAR, " Patient ' s DX distal fibial spiral FX. May return to use of assisted transfers with partial wt (weight) bearing with boot on if pain free; Continue boot but may remove several times a day for ankle Range of Motion in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

all planes as tolerated. "

R2's Nurse's Note, dated 8/2/15 7:24 PM, written by E9, (Licensed Practical Nurse) LPN documented, " Boot to L (left) foot intact, pedal pulse present."
R2's Nurse's Note, dated 8/4/15 at 9:33 AM, written by E13, LPN, documented, " Pedal pulse present to LLE (left lower extremity)."
R2's Nurse's Note, dated 8/4/15 7:19 PM, E13 documented, " Ortho boot remains in place with no redness to skin."
R2's Nurse's Note, dated 8/11/15 at 10:18 PM, E14 documented , LPN, documented, "Boot in place to left lower extremity, swelling has decreased a lot, no pitting edema noted at this time."
R2's Nurse's Note, dated 8/12/15 at 9:21 PM, written E14, "Boot in place to left lower extremity. Circulation and range of motion is good at this time."
8/15/15 9:23 PM, E14 Boot in place to left lower extremity. No problems observed related to circulation to the left foot and leg. "

Minimum Data Set (MDS) dated 8/13/15 documents R2 ' s Brief Interview for Mental Status (BMI)score as 15, cognitively intact and is totally dependent for transfers with assist of 2 staff.

On 9/29/15 at 12:00 PM, R2 stated, " Nobody ever took the boot off to check my leg. The only reason they took the boot off is because it was time for it to come off, I was supposed to wear the boot for 6 weeks. "

On 9/29/15 at 12:40 PM, E4, stated, " I removed the boot on 8/19/15 because (R2) was complaining of pain. When I took the boot off is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
0	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

when the wounds were first found. "

The following nurse's were interviewed on 9/30/15 regarding if they ever removed R2 's boot from her left leg between 8/2/15 through 8/20/15:

E6, LPN, stated at 5:40 PM, " Took it off to change dressing 1 time. "

E7 LPN, stated at 4:34 PM, " I only took boot off after she had wounds. "

E8, LPN, stated at 4:50 PM, "I only remember taking a boot off for a dressing change. "

E9, LPN, stated at 6:11 PM, " No, I never took the boot off. "

E10, LPN, stated at 4:53 PM, " No, I didn't take the boot off. "

E11, LPN, stated at 4:55 PM, " I can't remember taking the boot off. " E12, LPN, stated at 5:35 PM, " I removed it to do a dressing change only. "

E13, LPN, stated at 10:14 PM, " I don't even remember a boot; I don ' t remember ever removing a boot. "

E14, LPN, stated at 5:17 PM, " I checked under the boot 4 days after she had it on to see if the swelling had gone down, but that was the only time. "

E15, LPN stated at 9:19 PM, " No, I didn't ever remove the boot before there was an order."

E16, LPN, stated at 5:25 PM, " Didn't ever remove the boot. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

E17, LPN, stated at 5:27 PM, " No. "

E18, LPN, stated at 6:04 PM, " No, I never took it off at that time. "

E19, LPN, stated at 6:50 PM, " I only remember her having a dressing on her leg and never took the boot off otherwise. "

E20, LPN, stated at 5:39 PM, " I don't remember ever removing the boot before the 20th, only removed the boot to do a dressing change. "

E21, Registered Nurse (RN), stated at 6:40 PM, " No, I didn't. "

E22, RN, stated at 6:06 PM stated, " No. "

On 10/1/15 at 11:50 AM, Z2, RN for Z1 stated, " (R2) should have skin checks per facility protocol and physician ' s order. This was a significant error on the facility's part. "

R2's Nurse's Notes dated 8/19/15, at 5:37 PM, and Weekly Wound Flow Sheet dated 8/19/15, E21, LPN, documents, " Resident has two left lower leg skin tears, first one measuring 5cm(length)x0.1cm(depth)x2.5cm(width) and second one measuring 1cm(length)x0.1cm(depth)x0.5(wide). Also has 3 pressure spots on left great, left second and third toe, as well as wound on top of foot. " There were no measurements of the 3 pressure ulcers on R2's left great, left second and third toes.

Weekly Wound Flow Sheet, dated 8/19/15, documents, " Onset Date 8/19/15: " Left Lower Leg Skin Tear 5cmx0.1cm, Left lower leg Skin Tear 1cmx0.5cmx0.2cm, Pressure Left great toe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6 0.5x0.25cmxUTD (Unable To Determine), Pressure Left second toe 2cmx1.5cmxUTD, Pressure 0.5x0.5xUTD." 8/20/15 at 1:28 PM, E7, LPN, documents, " Call out to Z3, Physician, (Primary Care Physician) for skin check orders under brace q (every) shift, waiting on return call. " Z1 wrote the following orders on the TAR, dated 8/20/2015, " Skin checks to LLE under brace q (every) shift every shift for wound Wound Prevention Check skin under brace q shift. " Z4, Wound Physician's Wound Care Specialist Initial Evaluation form, dated 8/25/15, documents the following regarding R2's pressure ulcers: " Site 1, Unstageable (Due to Necrosis) Of The Left Lateral Calf, wound size (LxWxD) 3.5x3.0x Not Measureable cm (centimeter); Site 2, Stage 3 Pressure Wound Of The Left, Dorsal Foot 2.0x2.0x0.4 cm; Site 3, Unstageable (Due to Necrosis) Of The Left, Dorsal, Second Toe 0.3x0.5xNot Measurable cm; Site 4 Unstageable (Due to Necrosis) Of The Left, Dorsal, Third Toe 0.2x0.2x5xNot Measurable cm; Site 5 Unstageable (Due to Necrosis) Of The Left, Distal, Medial Foot 0.3x0.3xNot Measurable cm." R2 's dressing change was observed on 9/29/15 at 12:40 PM. E4, (LPN), removed the dressings from R2's pressure ulcers. R2 had the following pressure ulcers: The Left Lateral Calf, Stage 4 Pressure Wound, (LxWxD) 10.4x4.4x Not Measureable cm, muscle exposed, moderate serous sanguineous exudate slough, eschar, granulation. Left Dorsal Foot, Stage 4 Pressure Wound, 3.0x3xNotMeasureable cm, tendon exposed, Moderate serous exudates, slough, granulation. Left Dorsal, Second Toe, Unstageable (Due to Necrosis), 1.0x0.9xNot	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

Measurable cm, Moderate serous exudates, slough, eschar.
Left Distal, Medial Foot, Unstageable (Due to Necrosis) Of 0.4x0.4xNot Measurable cm, no exudate.

Facility Policy #CN-1801 (undated) documented, " Skin/Pressure Ulcer Risk Evaluation 6. The licensed nurse will remove, inspect, and provide skin care to the skin of the resident with braces, splints and associated wrappings, or other devices every shift and prn (as needed), unless contraindicated by the physician. The findings of the skin inspection will be documented on the Treatment Administration Record (TAR). "

2. R1's Hospital discharge summary dated 8/17/15 documented, " Wear TLSO (Thorsacolumbar Sacral, Orthosis Brace) at all times. "

Nurse Notes dated 8/21/15 at 12:00 PM, E5 documents, " Message left with Z5, Physician, office regarding resident TLSO brace. Brace rides up really bad on resident when she sits down and resident is complaining of pain in underarms. This writer afraid if this isn't adjusted then it may cause sores or bruising. Requesting information on who adjusts braces or who to call. Awaiting return call. "

8/26/15 at 12:33 PM, E5 documents, " Explanation of skin concerns and treatments: redness and discoloration under arms r/t (related to) brace applying pressure to area, dry foam applied to prevent further skin issues.

9/10/15 at 12:47 PM, E5 documents, " Z5 ordered, R1 has to have TLSO brace on. Okay to take off at night when lying in bed. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

Pressure Ulcer log documents R1's pressure areas as:
"8/26/15, Left axillary arm Pressure 2.4x5.0xUTD, Right axillary arm Pressure 0.7x6.0xUTD."

" 9/15/15, Midline upper back Pressure 2.2x0.8xUTD. "

Nurses Note by E5, dated 8/26/15 12:48 PM, Resident c/o (complained) pain under arms where TLSO brace presses. Observed area and noted redness and discoloration where brace lays. Areas blanchable although new order obtained to apply dry foam dressing on area to reduce pressure and prevent further skin issues. Resident has appt (appointment) with (Clinic) tomorrow 8-27-15 to refit brace. "

Clinic report dated 8/27/15, " Follow up visit today to adjust the TLSO fit at hospital on 8/13/15. Today the patient arrived with the orthosis in place. The patient complains that it is not fitting well. The patient complains that the TLSO is riding up and choking her. The patient also states that it is digging into her abdomen. I removed the orthosis and trimmed the anterior and posterior shells. I also replaced all six anterior shell straps as they were heavily soiled. I reapplied the orthosis and marked new straps for proper fit. The patient is pleased with the results. The patient will follow up with our office with ant other problems or concerns. "

Wound Care Specialist (Z4) Evaluation dated 9/1/15, " Site 3 Unstageable (Due to Necrosis) Of the Left, Axillary Area Arm Pressure 2.0x8.5xNot Measureable cm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9 Site 4 Unstageable (Due to Necrosis) Of the Right, Axillary Area Arm Pressure 1.0x5.0xNot Measureable cm. On 9/29/15 at 11:05 AM, E5, LPN, stated, " I called the doctor ' s office on 8/21/15 and left a message about getting (R1's) brace needing to be trimmed because it was making under her arms red, I ' m not sure when they called back. I did not follow up with another phone call. " Minimum Data Set (MDS) dated 9/14/15 documents R1 ' s Brief Interview for Mental Status (BMI) score as 15, cognitively intact and is extensive assist for transfers with assist of 2 staff. On 9/30/15 observed R1 at 11:00 AM sitting in wheelchair wearing her TLSO brace. On 9/30/15 at 1:30 PM R1 was laying in bed with her brace off. R1 had dressings on her left and right axilla, mid back, and right buttocks. Wound Care Specialist Initial Evaluation, dated 9/29/15, Z4, Wound Physician (MD) documents, " Stage 3 Pressure Wound Of The Left, Axillary Area Arm Pressure 1.0x0.3x0.3 cm. Unstageable (Due to Necrosis) Of the Right, Axillary Area Arm Pressure 0.50x0.5xNot Measureable cm. Unstageable (Due to Necrosis) Of the Midline Back, 1.6x0.5x5xNot Measureable cm. " Interview on 9/30/15 at 1:30 PM, R1 refused dressing changes. R1 stated, I have areas under her armpits that bleed and my back and butt have wounds on them. That brace is killing me. "	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10 (B)	S9999		